

**SETTLEMENT EVALUATION OF THE CERTIFICATE OF NEED APPLICATION
SUBMITTED ON BEHALF OF KADLEC MEDICAL CENTER PROPOSING TO ADD
FIFTY-EIGHT ACUTE CARE BEDS TO THE HOSPITAL**

September 29, 2006

PROJECT DESCRIPTION

Kadlec Medical Center (KMC) is a non-profit, acute care hospital located at 888 Swift Boulevard in the city of Richland, within Benton County. KMC is currently a provider of Medicare and Medicaid services to the residents of Benton and Franklin counties and surrounding areas. As of the writing of this settlement evaluation, KMC is licensed for 172 acute care beds and operates an 8-bed intermediate care nursery with level II obstetric services. KMC also provides Medicare and Medicaid home health services to the residents of Benton and Franklin counties through its home health agency known as Kadlec Home Health. The hospital holds a three-year accreditation from the Joint Commission on Accreditation of Healthcare Organizations and is one of three hospitals participating in the Tri-Cities Trauma Services.¹ [source: AR 869]

BACKGROUND INFORMATION

On December 30, 2004, KMC submitted a Certificate of Need application proposing to add 58 acute care beds to its the hospital. At the time of application, KMC was licensed for 153 acute care beds, and if all 58 beds were approved, KMC would be operating a facility total of 211 acute care beds. The 58 beds would be added in two phases, which are described below. [source: AR 005, 014, 023]

Phase One

19 of the 58 beds would be added in this phase, with 10 for medical/surgical unit and 9 for the pediatric unit. Phase one would commence immediately after CN approval and be complete by September 2005. This phase requires no construction or purchase of equipment and, therefore, requires no capital expenditure.

Phase Two

Currently, KMC is constructing a new patient tower. This phase includes completing two floors in the tower and adding the remaining 39 beds--28 beds in the critical care unit and 11 in the medical surgical unit. Phase two would be complete and operational by October 2007. The estimated capital expenditure of \$13,571,066 for the project was solely attributed to phase two. [source: AR 044]

On August 1, 2005, the Program completed its review of KMC's bed addition application and determined that the two-phase, 58-bed addition project described by KMC within its application was not consistent with the Certificate of Need criteria. However, the Program concluded that the addition of 19 beds, or phase one of the project, was consistent with the review criteria. Certificate of Need #1315 was issued approving phase one only which increased KMC's acute care beds from 153 to 172. [source: AR 866-868] On January 27, 2006, the Program

¹ The other two hospitals participating in the Tri-Cities Trauma Services is Kennewick General Hospital located in the city of Kennewick within Benton County and Our Lady of Lourdes Health Center located in the city of Pasco within Franklin County.

acknowledged KMC's addition of 19 acute care beds, and concluded that the project authorized under CN #1315 was complete.

On August 24, 2005, KMC filed its Application for Adjudicative Proceeding with the department's Adjudicative Service Unit (ASU). On September 19, 2005, ASU identified a January 23, 2006, hearing date for the adjudicative proceeding. [source: ASU Scheduling Order/Notice of Hearing] Between October 24, 2005, and June 27, 2006, the hearing date was twice rescheduled. During that time, the Program and Kadlec Medical Center explored conceptual settlement alternatives that could result in the matter being settled without the need for an adjudicative proceeding.² On June 24, 2006, the Program and KMC entered into a conceptual agreement regarding the possibility of settlement. [source: Prehearing Orders 1 & 2; and Stipulation and Agreed Order Staying Adjudicative Proceeding and Remanding to Certificate of Need Program, signed and dated June 27, 2006]

APPLICANT'S SETTLEMENT OFFER

Consistent with the Stipulation and Agreed Order Staying Adjudicative Proceeding and Remanding to Certificate of Need Program, on July 21, 2006, the Certificate of Need Program requested additional clarifying information related to KMC's conceptual settlement discussions. On August 25, 2006, KMC provided its response to the Program's request.

Within its responses, KMC requested approval of a portion of phase two of the project described above. As noted above, in the application, phase two includes completion of two floors in the tower (floors 3 and 5) and an addition of 39 beds--28 beds in the critical care unit and 11 in the medical surgical unit. KMC's August 25 settlement offer requests approval of 17 of the 39 beds. With an additional 17 beds, KMC would be operating 189 acute care beds. To accommodate the additional 17 beds, a 28-bed nursing unit would be built on the 4th floor of the patient tower; the nursing unit would accommodate the 17 new beds, as well as another 11 beds reduced from other areas of the hospital. Within the settlement documents, KMC states that construction of the space that would house the 17 beds would begin in April 2008, and the additional 17 beds would be operational by July 2008. [source: Settlement documents, pp6-7]

In the initial application, KMC identified a zero capital expenditure for phase one of the project and \$13,571,066 for phase two. Within the settlement documents, given that KMC reduced its request from 39 beds to 17 beds, the estimated capital expenditure was reduced to \$9,549,452. Of that amount, 68% is related to construction; 20% is related to equipment (both fixed and moveable); 8% is related to state sales tax; and the remaining 4% is related to fees. [source: Settlement documents, p5]

APPLICABILITY OF CERTIFICATE OF NEED LAW

This project is subject to Certificate of Need review as the change in bed capacity of an existing health care facility under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(e) and Washington Administrative Code (WAC) 246-310-020(1)(c).

² Under RCW 34.05, the department may engage in settlement discussions and reach an informal settlement on matters that may make the adjudicative appeal unnecessary.

INITIAL APPLICATION CHRONOLOGY

October 27, 2004	Letter of Intent Submitted
December 30, 2004	Application Submitted
December 31, 2004 through February 21, 2005	Department's Pre-Review Activities <ul style="list-style-type: none">• 1st screening activities and responses• 2nd screening activities and responses
February 22, 2005	Department Begins Review of the Application <ul style="list-style-type: none">• public comments accepted throughout review
April 22, 2005	Public Hearing Conducted/End of Public Comment
May 9, 2005	Rebuttal Documents Received at Department
June 23, 2005	Department's Anticipated Decision Date
August 1, 2005	Department's Actual Decision Date

ADJUDICATIVE APPEAL CHRONOLOGY

August 24, 2005	Applicant's Request for Adjudicative Proceeding
September 19, 2005	ASU's Scheduling Order/Notice of Hearing
October 24, 2005	ASU's Prehearing Order #1: Order Continuing Scheduling Order
February 19, 2006	ASU's Prehearing Order #2: Order Continuing Prehearing Conference and Hearing Dates
June 5, 2006	ASU's Prehearing Order #3: Order Defining Conduct of Hearing
June 27, 2006	Stipulation and Agreed Order Staying Adjudicative Proceeding and Remanding to Certificate of Need Program (signed by HLJ)
August 25, 2006	Prehearing Order #4: Order of Continuance

AFFECTED PERSONS/INTERVENORS

For the initial application, the following two entities sought and received affected person status under WAC 246-310-010:

- Kennewick General Hospital located in the city of Kennewick within Benton County; and
- Our Lady of Lourdes Health Center located in the city of Pasco within Franklin County.

During the course of the adjudicative appeal, one entity--Kennewick General Hospital--sought and received intervenor status with the ASU. As an intervenor, Kennewick General Hospital has an opportunity to comment on any proposed settlement prior to any finalization of a settlement. [source: June 27, 2006, Stipulation and Agreed Order Staying Adjudicative Proceeding and Remanding to Certificate of Need Program]

SOURCE INFORMATION REVIEWED

- Kadlec Medical Center's Certificate of Need Application received December 30, 2004
- Kadlec Medical Center's supplemental information dated February 3, 2005, and February 25, 2005
- Kadlec Medical Center's August 21, 2006, settlement documents (received August 25, 2006)

- Community members' comments
- Documents and comments received at the April 22, 2005, public hearing
- Rebuttal comments received from Kadlec Medical Center dated May 6, 2005
- Rebuttal comments received from Kennewick General Hospital dated May 9, 2005
- Comprehensive Hospital Abstract Reporting System (CHARS) data obtained from the Department of Health's Office of Hospital and Patient Data Systems
- Financial feasibility and cost containment evaluation prepared by the Department of Health's Office of Hospital and Patient Data Systems (June 14, 2005)
- Historical charity care data obtained from the Department of Health's Office of Hospital and Patient Data Systems (2001, 2002, and 2003 summaries)
- Population data obtained from the Office Financial Management based on year 2000 census published January 2002.
- Licensing and/or survey data provided by the Department of Health's Office of Health Care Survey
- Emergency and trauma designation data provided by the Department of Health's Office of Emergency Medical and Trauma Prevention
- Acute Care Bed Methodology extracted from the 1987 State Health Plan
- Data obtained from Kadlec Medical Center's website
- Data obtained from the internet regarding health care worker shortages in Washington State
- Data obtained from the internet regarding Kadlec Medical Center's project
- Certificate of Need Historical files

CRITERIA EVALUATION

To obtain Certificate of Need approval, Kadlec Medical Center must demonstrate compliance with the criteria found in WAC 246-310-210 (need); 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); and 246-310-240 (cost containment), and portions of the 1987 State Health Plan as it relates to the acute care bed methodology.³

CONCLUSION

On August 1, 2005, Kadlec Medical Center was issued Certificate of Need #1315 approving phase one only--19 acute care beds. On January 27, 2006, the Program acknowledged KMC's addition of 19 acute care beds--a facility total of 172--and concluded that the project authorized under CN #1315 was complete.

For the reasons stated in this settlement evaluation, the Certificate of Need Program approves the addition of 16 more beds at Kadlec Medical Center. At project completion, Kadlec Medical Center would be operating 188 acute care beds.

The approved capital expenditure associated with the addition of 16 more beds is \$9,549,452.

³ Each criterion contains certain sub-criterion. The following sub-criteria are not discussed in this evaluation because they are not relevant to this project: WAC 246-310-210(3), (4), (5), and (6).

A. Need (WAC 246-310-210)

Based on the source information reviewed and agreement to the addition of 16 acute care beds, the department determines that the applicant has met the need criteria in WAC 246-310-210.

1987 State Health Plan Numeric Need Calculations

In its August 1, 2005, initial evaluation, the department concluded that KMC's application to add 58 acute care hospital beds was not consistent with the criterion of need. However, KMC's project was consistent with the need criterion provided that only 19 beds--or phase one of the project--was implemented. That conclusion was based, in part, on the following rationale.

- 1) Application of the Hospital Bed Need Forecasting Method contained in the 1987 Washington State Health Plan used to assist in the determination of need for acute care capacity projected that the Benton-Franklin planning area would require additional bed capacity in year 2008 if no new beds were added to the planning area. [source: AR 899]
- 2) If both phases--all 58 beds--were added to the planning area, the numeric methodology resulted in a surplus of 71 beds in 2008. The surplus decreased to 40 beds in 2012. A review of Appendix 10B attached to this evaluation indicates that the bed surplus continued through year 2016. In Year 2017--12 years from the date of the initial evaluation--the planning area began to show a need for 9 beds, which increased to 40 beds by the end of 2020.
- 3) If only 19 beds were added to the planning area (phase one), year 2006 projected a surplus of 30 beds, which decreased to a 5 bed surplus in year 2010. The department acknowledged that the methodology projected need for beds in 2011.
- 4) While the Program acknowledged that the addition of only phase one, or 19 beds, in the planning area may result in a need for additional bed capacity as early as year 2011, the application did not appear to contain extensive data that allowed the Program to approve only a portion of phase two. As a result, the Program concluded that the addition of all 39 beds in phase two would overbed the planning area through at least 2017, which is five years beyond the seven year planning horizon targeted for acute care bed addition applications. Therefore, the entire phase was denied. [source: AR 872-881]

Within KMC's settlement documents, KMC provided the following rationale to support its numeric need request for 17 of the 39 beds requested in phase two.

- 1) If no new beds are added to the planning area, application of the numeric methodology projected that the Benton-Franklin planning area would require 36 additional beds in year 2012. [source: AR 899]

Program's Numeric Need Evaluation

It is not disputed that application of the numeric bed methodology demonstrated a need for additional bed capacity in the Benton-Franklin planning area as shown in Appendix 10A attached to the initial evaluation [source: AR 899] The dispute appears to be: "How many beds are needed?"

In its application, KMC asserted that 58 beds were needed. This assertion was supported by KMC's use of the high population series when applying the numeric methodology. [AR 426-

427] The Program has consistently used the intermediate population series in its numeric methodologies. Further, the addition of all 58 beds requested in KMC's application would over-bed the planning area through 2016, which is five years longer than the seven years recommended within the state health plan for bed addition projects. In essence, KMC proposed that the department forecast to 2020 to justify the addition of all 58 beds to the planning area. [source: AR 900]

The Program, on the other hand, disagreed with KMC's assertion that 58 beds were needed in the planning area. Using the medium series population, the numeric methodology projected a need for 35.23 (rounded to 36) beds in year 2012. Using year 2012 as the planning year is consistent with the seven year forecast recommended in the state health plan. Under this settlement, KMC requests approval of a total of 36 beds to the planning area; acknowledging implementation of the 19 beds under CN #1315, KMC now requests the remaining 17 beds. [source: Settlement documents, p1]

When reviewing applications for acute care bed additions, the Program applies the numeric methodology to the planning area using the assumption that no new beds are added. This approach provides the Program with a base-line net need (or net surplus) of beds in a planning area. As previously stated, this portion of the methodology projected need for 36 additional beds in year 2012 in the Benton-Franklin planning area (Appendix 10A).

The KMC bed addition project was presented as a two phase project. Phase one--the first 19 beds--would be added immediately, and the remaining 39 beds in phase two would be added in October 2007. To apply the numeric methodology for multi-phase projects, the Program includes the requested number of beds in each of the years identified by the applicant. A summary of the two-phase calculations for KMC's 58-bed project is shown in Table I below. [source: AR 1009]

Table I
Appendix 10C Summary

	2005	2006	2007	2008	2009	2010	2011	2012
# of beds	314	333	333	333	333	333	333	333
Appendix 10C	-15.76	-29.53	-23.46	-17.35	-11.18	-4.95	5.14	15.31

A negative number indicates a surplus of beds. All numbers would be rounded up to whole numbers

As shown in Table I above, in year 2006 with an additional 19 beds, the planning area shows surplus of 30 beds, which decreases to a 5 bed surplus in year 2010. By year 2012, the planning area is projected to need an additional 15.31 beds in year 2012. Consistent with past practices, the Program would round the 15.31 need to 16. The Program also applied the numeric methodology to the planning area assuming that 16 additional beds are added in year 2009. Appendix 10D attached to this evaluation shows the calculations through 2020. A summary of Appendix 10D is shown in Table II on the following page.

Table II
Appendix 10D Summary

	2008	2009	2010	2011	2012	2013	2014	2015
# of beds	333	349	349	349	349	349	349	349
Appendix 10D	-17.35	-26.85	-20.62	-20.63	-0.34	9.91	20.24	30.64

A negative number indicates a surplus of beds. All numbers would be rounded up to whole numbers

As shown in Table II above, adding another 16 beds in year 2009 results in a surplus of one bed in year 2012, which is seven years after the addition of the 19 beds in phase one. This timeline is consistent with the recommended planning horizon in the state health plan. Year 2013 begins to show a need for ten beds, which increase to 31 beds by the end of year 2015. As a result, the Program would consider the approval of 16 additional beds, rather than the 17 requested by KMC in phase two of its project.

(1) The population served or to be served has need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need.

In its August 1, 2005, initial evaluation, the department concluded that the project was consistent with this sub-criterion based on the following rationale. [source: AR 880-882]

- 1) A review of CHARS data supported KMC's assertion that its historical utilization was typically higher than the utilization of either Kennewick General Hospital located in Benton County or Our Lady of Lourdes Health Center located in Franklin County.
- 2) CHARS data also supported KMC's assertions that it received an increasing number of referrals from the smaller, rural hospitals located within the Dayton and Prosser service areas adjacent to the Benton-Franklin planning area.
- 3) the 20+ letters of support for the addition of beds to KMC. Two hospitals in Oregon-- Good Shepherd Health Care System in Hermiston and St. Anthony Hospital in Pendleton--indicated support of this project based on the referral relationships they have in place--or will have in place--with KMC. While the Program could not approve beds in a Washington Hospital specifically to serve Oregon residents, historical utilization data obtained from CHARS supported the two Oregon hospitals assertions of continued and increased use of KMC by Oregon residents. Out-of-state resident use of a hospital located near or on a border is not uncommon, and the numeric methodology allows those patients to be counted in the utilization of the facility under review. However, given that Washington State DOH does not have any regulatory authority in the state of Oregon, the department could not solely rely on the continued use of a border hospital by out-of-state residents as a demonstration of need for additional bed capacity.

Within its August 21, 2006, settlement documents, KMC provided the following rationale to support this sub-criterion. [source: Settlement documents, pp2-3]

- 1) Use of the Benton-Franklin hospitals by the residents of the Benton-Franklin planning area is increasing each year; the preference appears to extend to residents of the adjacent communities, which increases patient in-migration to the Benton-Franklin providers.
- 2) KMC has increasingly high inpatient census levels which compromises its ability to admit and manage patients in a timely manner.

- 3) In early year 2005, Our Lady of Lourdes Health Center located in the city of Pasco within Franklin County obtained Critical Access Hospital designation, thereby decreasing its number of licensed beds from 95 to 25.

Program's Need Evaluation

The information provided by KMC to demonstrate community need for the additional beds was previously provided within the application and appropriately reviewed and addressed by the Program in its August 1, 2005, initial evaluation. The conclusions in this settlement evaluation regarding numeric need do not change the Program's conclusion that need for the project was demonstrated.

Based on the above evaluation, under this settlement evaluation, KMC's project is consistent with the need criterion provided that an additional 16 beds are added to the hospital.

- (2) All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services.

In its August 1, 2005, initial evaluation, the department concluded that KMC effectively demonstrated that all residents of the service area currently have adequate access to its health services. Further, the department concluded that the addition of 19 beds--phase one of the initial project--would not negatively affect this access, and patients would continue to have access to the health services at KMC. Further, the department concluded that a condition related to the percentage of charity care to be provided at KMC was not necessary. [source: AR 882]

Within its settlement documents, there was no additional information provided that would change this conclusion. Based on the information above, the department concludes that this sub-criterion remains met.

B. Financial Feasibility (WAC 246-310-220)

Based on the source information reviewed and agreement to the approval of 16 acute care beds, the department determines that the applicant has met the financial feasibility criteria in WAC 246-310-220.

- (1) The immediate and long-range capital and operating costs of the project can be met.

In its August 1, 2005, evaluation supporting the issuance of CN #1315, the department concluded that this sub-criterion was met based on the following factors.

- 1) A review of the hospital's projected patient utilization with 172 licensed acute care beds used for acute care services. This review included proposed revenues, expenses, and net profit for KMC in years 2005 through 2010.
- 2) A review of KMC's projected financial ratios for years 2007 through 2010.

[source: AR 883-885]

Within its August 21, 2006, settlement documents, KMC indicated that it anticipates no change in the projected number of non-newborn admissions or patient days with the addition of 17 beds rather than the 39 requested in the initial application. Rather, KMC expects its

occupancy percentages would be higher with the decreased number of additional beds. [source: Settlement documents, p3 & pp8-9]

Program's Evaluation

In the initial application, KMC projected 42,093 patient days in year 2006⁴ as a 172-bed hospital--or after the addition of 19 beds. In subsequent years, patient days were projected to increase an average of 6% per year through year 2010. In its initial evaluation, the Program concluded KMC could reach its projected patient days through year 2010 with the addition of only 19 beds. [source: AR884-885]

Within the settlement documents, KMC provided a table showing the projected number of patient days and occupancy of KMC with an additional 17 beds (189 bed facility). The projected patient days remained the same for years 2007 through 2010. With 17 more beds, the projected occupancy was projected to be 64.6% in year 2007, and increased 77.2% in year 2010. KMC also noted that the State Health Plan target occupancy for a 189-bed hospital is 70%. [source: Settlement documents, pp2-3]

Within the need portion of this settlement evaluation, the department concluded that the addition of 16 beds is justified. Within the initial application, the Program applied simple calculations to determine whether KMC could reach its anticipated number of patient days in years 2007 through 2010 with 172 beds (the addition of 19 beds only). Those calculations showed that KMC could reach its projected patient days, however the facility's occupancy would be quite high by the end of year 2010. [source: AR 885] As a result, the Program would also conclude that KMC could reach its projections with an additional 16 beds--or as an 189 bed hospital.

Given that the facility could reach its projected patient days through year 2010, the department concludes that KMC would be able to meet its short and long term financial obligations, and the capital and operating costs of the project would be met as an 189 bed hospital. This sub-criterion is met.

(2) *The costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services.*

In its August 1, 2005, evaluation supporting the issuance of CN #1315, the department concluded that this sub-criterion was met based on the following factors. [source: AR 885]

- 1) A comparison review of KMC's costs and charges to the year 2003 statewide average by staff of the Department of Health's Office of Hospital and Patient Data Systems (OHPDS) concluded that they are reasonable if KMC were to add all 58 beds.
- 2) There is no capital expenditure associated with the addition of the 19 beds in phase one. Given that phase two of this project was determined not to be needed, the department concluded that approval of phase one of this project would not result in an unreasonable impact on the costs and charges for health services within the service area

Within its August 21, 2006, settlement documents, KMC provided a revised capital expenditure breakdown for the project. KMC estimates a capital expenditure reduction for

⁴ All patient day projections exclude DRG 391-normal newborn.

phase two from \$13,571, 066 to \$9,549,452. Table III below shows a cost comparison for the 39 bed initial project and KMC's 17 bed settlement request. [source: Settlement documents, p5]

Table III
Kadlec Medical Center
Estimated Capital Expenditure Comparison

Description	39-bed Addition	17-bed Addition
Building Construction	\$ 9,900,000	\$ 6,495,828
Equipment (moveable and fixed)	1,884,884	1,905,752
Washington State Sale Tax	1,036,826	736,275
Fees (incl CN, CRS, consultant)	749,356	411,597
Total	\$ 13,571,066	\$ 9,549,452

KMC also provided the following explanation related to the decrease. [source: Settlement documents, p5]

“[In the application] phase II proposed to add 39 beds on the 4th and 5th floors of a to-be-constructed tower. The estimated cost of phase II was \$13,571,066. With the settlement proposal of 17 beds, Kadlec proposes to only finish the 4th floor for patient care. As such, the estimated capital expenditure is less than that identified in the CN for Phase II. However, given that nearly two years has lapsed since Kadlec’s original submittal, and give that construction costs have escalated beyond inflation over the past year or so, we now estimate the capital expenditure associated with finishing the 4th floor for patient care to be \$9.5 million.”

Based on the information summarized above regarding the amended capital costs, the Program concludes that the capital costs for the addition of 17 acute care beds is reasonable. In the numeric need portion of this evaluation, the Program concluded that the addition of 16 acute care beds, rather than the 17 requested by KMC. The Program recognizes that completion of the 4th floor would still occur for the 16 beds, and any reduction in capital costs from 17 to 16 beds would be minimal. As a result, the Program concludes this sub-criterion is met.

(3) *The project can be appropriately financed.*

In its August 1, 2005, evaluation supporting the issuance of CN #1315, the department concluded that this sub-criterion was not applicable because there was no capital expenditure associated with the 19 bed addition. However, within its initial application proposing to add 58 acute care beds to the hospital, KMC provided detailed information regarding the source of funding for the project. [source: AR 46 & 202] The Program’s review of the documentation follows.

KMC identifies the estimated capital expenditure to be \$9,549,452, and of that amount, 68% is related to building construction, 20% is related to equipment (both fixed and moveable); 8% is related to state sales tax; and the remaining 5% is related to permits and fees. [source: Settlement documents, p5]

KMC intends to fund the project through tax exempt bonds, and years 2006 and 2007 hospital reserves/operations. [source: AR 46, 202] To demonstrate that the funding is available, KMC provided a copy of its audited financial statements for years 2001 through 2003.⁵ [source: AR 146-190]

After reviewing KMC's audited financial reports, OHPDS provided the following statements regarding the initial, two-phase project:

“Kadlec Medical Center’s capital expenditure is projected to be \$13,571,066 or 9.11% of 2003 total assets. The system notes: ‘\$40 million of the required funding for the Master Facility plan will be funded with tax exempt bonds. These bonds will be issued through the Washington Health Care Facilities Authority. The remaining \$19 million will be funded from a combination of reserves and operations.’ The applicant in the [application] screening response stated that the funding source for the CN portion is \$4,950,431 from net bond proceeds in 2005, \$4,310,318 cash from operations/reserves in 2006, and another \$4,310,318 cash from operations/reserves in 2007. Review of the Bond finance rate shows it to be appropriate. The hospital’s recent cash flow from operations also makes the projected use of operating funds realistic. Further review shows that while this project will have a considerable impact to the hospital; this project will not adversely impact the reserves, or total assets, total liability or the general health of the hospital in a significant way. The financing methods used are appropriate business practice. [source: AR 960-961]

Based on the source information reviewed for KMC’s initial project and the review performed by OHPDS above, the department concludes that the proposed financing is the most prudent approach, and would not negatively affect KMC’s total assets, total liability, or general financial health. This sub-criterion is met.

C. Structure and Process (Quality) of Care (WAC 246-310-230)

Based on the source information reviewed and agreement to the approval of 16 acute care beds, the department determines that the applicant has met the structure and process (quality) of care criteria in WAC 246-310-230.

(1) A sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited.

In its August 1, 2005, initial evaluation; the department concluded that a sufficient supply of qualified staff would be available or recruited to staff the additional 58 beds proposed to be used for acute care services. Additionally, the Program recognized that the reduction in the number of approved beds and the subsequent reduction in the number of needed staff would not change the conclusion for this sub-criterion. [source: AR885-886]

Within its August 21, 2006, settlement documents, KMC provided the following rationale for no changes in proposed staffing with the addition of 17 acute care beds. [source: Settlement documents, p11]

⁵ Given that KMC’s initial application was submitted on December 30, 2004, the use of 2001-2003 audited data is appropriate.

“Because we are projecting the same number of patient days--even with fewer beds--and because our staffing is predicated on census, no increase in FTEs beyond that identified in the Attachment #4 to Kadlec’s February 3, 2005 screening responses is projected with the 17 settlement beds requested.”

Based on KMC’s rationale above, the Programs recommended reduction of approved beds from 17 to 16 is not expected to affected KMC’s projected census or staffing. Based on the information provided in the application, the department concludes that KMC provided a comprehensive approach to recruit staff necessary for the additional beds. [source: AR 247-248] The reduction in the number of approved beds does not change the department’s conclusion regarding this sub-criterion. This sub-criterion is met.

- (2) *The proposed service(s) will have an appropriate relationship, including organizational relationship, to ancillary and support services, and ancillary and support services will be sufficient to support any health services included in the proposed project.*

In the initial application, KMC demonstrated that the addition of 58 acute care beds would not change any existing relationships with ancillary and support services. Patients would continue to have access to the least restrictive level of acute care services at the hospital. Further, in the initial application, KMC stated that it would continue to be responsible for all ancillary and support services provided to acute care patients. Additionally, ancillary and support services would be provided under existing contracts with the appropriate vendor and the hospital. [source: AR 886]

Within KMC’s settlement documents, there was no additional information provided that would change this conclusion. This sub-criterion remains met.

- (3) *There is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, if the applicant is or plans to be certified under the Medicaid or Medicare program, with the applicable conditions of participation related to those programs.*

In its August 1, 2005, initial evaluation, the department concluded that there was reasonable assurance that KMC would continue to operate in conformance with applicable state and federal licensing and certification requirements. This conclusion was based on the following factors:

- 1) KMC’s historical compliance with applicable state licensing requirements, and continued participation under the Medicaid and Medicare program; and
 - 2) KMC’s home health agency’s historical compliance with applicable state licensing requirements, and continued participation under the Medicaid and Medicare program.
- [source: AR886-887]

Within KMC’s settlement documents, there was no additional information provided that would change this conclusion. This sub-criterion remains met.

- (4) The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system.

In its August 1, 2005, initial evaluation, the department concluded that the project would promote continuity in the provision of health care with the existing providers in the community. [source: AR 887]

Within KMC's settlement documents, there was no additional information provided that would change this conclusion. This sub-criterion remains met.

- (5) There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules, and regulations.

This sub-criterion is addressed in sub-section (3) above and is considered met.

D. Cost Containment (WAC 246-310-240)

Based on the source information reviewed and agreement to the approval of 16 acute care beds, the department determines that the applicant has met the cost containment criteria in WAC 246-310-240.

- (1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.

In the initial application, KMC demonstrated that the addition of acute care beds was justified for the planning area. As previously stated, the question of "how many acute care beds are needed" was at issue. In the August 1, 2005, initial evaluation, the Program concluded a 19-bed addition at KMC was appropriate and considered the best available alternative for the planning area based on the following factors:

- 1) the state health plan's recommended planning horizon through year 2012;
- 2) the current number of beds in the planning area; and
- 3) the declining utilization at Kennewick General Hospital and the increasing utilization at KMC.

[source: AR, 887-888]

Within KMC's settlement documents, there was no additional information provided that would change this conclusion. Further, based on KMC's application, the Programs recommended reduction of beds from 17 to 16 would not be expected to change the department's conclusion regarding this sub-criterion. This sub-criterion remains met.

APPENDIX D